Kansas Department of Health and Environment

Nursing Facilities Program

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In this issue....

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Resident Assessment Instrument

The following are some of the most frequently asked questions concerning the resident assessment instrument.

Who can complete the MDS+?

On page 24 and page 34 of the **Minimum Data Set Plus Reference Manual** this question is discussed. Each assessment must be conducted or coordinated by a registered nurse, with participation of appropriate health care professionals. This process is illustrated on page 10 of this *Fact Sheet*. The individuals identified in the elliptical items are resources for the health care professional. The rectangular items indicate health care professionals who may code assessment items on the MDS+.

Sections B, C, D, E, F, H, I, J, K, M, N and O must be completed by an appropriate health care professional. The items in these sections require professional judgment. Health care professionals include, but not limited to licensed nurses (RN's and LPN's), licensed social workers, physical therapists, occupational therapists, speech language pathologists, recreational therapists and dietitians. The Kansas Nurse Practice Act does not allow nurses to delegate the function of assessment to an unlicensed individual. Licensed Practical Nurses may perform portions of the assessment as long as they can demonstrate that they have had additional education in the area of assessment and a registered nurse has determined that they are competent to perform an assessment.

Section L maybe completed by a food service supervisor and Section G by an activity director who is also a nurse aide. The assessment items in these sections are factual and do not require professional judgement. Section A items are also factual, therefore that section can be completed by a nurse aide or medical records designee.

It is essential that all members of the health care team be involved in the assessment process. The resident, resident's family, nurse aides, housekeepers and others in the facility who have knowledge of the resident should be used as sources of information. The functioning of the resident over the period specified must be evaluated before a health care professional can determine how to code the assessment. On initial admissions, it is essential to

obtain information concerning the resident's functional capacity prior to admission. This information is especially needed to complete Section II of the Intake page.

Each individual who completes a portion of the MDS+ must document the section they completed and sign the form in Section P. By signing at Section P, the RN Coordinator is certifying that the assessment has been completed. The RN Coordinator is not held accountable for the accuracy of the sections performed by other health care professionals.

There have been many questions concerning the Resident Assessment Protocol system (RAPs). On page 11 of this *Fact Sheet* is a diagram of the RAPs process. This diagram is an attempt to illustrate the process described on pages 217 through 220 of the *Minimum Data Set Plus Reference Manual*. Discussed below are several issues which are identified as problems encountered by facilities in completing the RAPs process.

1. A RAP must be reviewed if the RAP definition is met. Some RAPs are triggered by one item on the MDS+. Some trigger definitions include a combination of items. If the specific combination of items is not found on the assessment, the RAP has not been triggered.

   Example: Delirium RAP

   (1) On the assessment, it was indicated that the resident experienced a decline in communication (C7 = 2). C7 = 2 is an automatic trigger. Facility staff would be required to REVIEW the guidelines to determine if there is a need to care plan for the problem of delirium.

   (2) The assessment indicated that the resident had experienced a decline in mood (E6 = 2). To meet the trigger definition, the resident assessment would need to indicate one or more of the following items were checked: motor agitation, withdrawal, hallucinations or delusions. If the additional items were not found, the RAP would not be reviewed as the trigger definition was not met.

   It has been identified that some software programs print out actual and potential triggers regardless of the trigger definition. Facilities should review their software to determine if this is happening. Surveyors have identified that a number of facilities are reviewing RAPs which do not need to be reviewed.

2. When the trigger definition for a RAP has been met, the RAP guidelines need to be reviewed. The guidelines provide information on potential areas for further assessment to determine whether a care plan needs to be developed to deal with the triggered problem. Facilities are not required to document review of every item in the guidelines. Additional assessment, however, must be performed when review of the guidelines indicate causative factors which may affect the potential problem identified on the assessment.

3. Perform the additional assessment. Contact appropriate health care providers for additional input. This could include referral to the dietitian for a review of risk factors related to unplanned weight loss, or to a physical therapist or occupational therapist for a resident identified at risk for falling.

   The individual assigned the responsibility for reviewing the RAP must document a summary of problems, complications and risk factors identified and the rationale to proceed or not to proceed to care planning. The summary may include references to progress notes, and/or specific assessment forms included in the clinical record. A standardized form maybe used as long as the above elements are included.

4. The care plan must reflect the findings in the assessment and RAP review. The facility does not have to develop a problem for each RAP review which indicated the need for care planning. One should be able to identify the issues found in the RAP review in the care plan.

A6. Reason for Assessment

This item indicates the **primary** reason for performing the assessment. Item 7 is only to be used for the second assessment required for initial admissions for facilities participating in the Medicaid program. In those instances when a reassessment is required due to a survey finding of inaccurate assessment, the assessment would in most instances be coded as a quarterly assessment unless the assessment results meet the definition for a significant change assessment.

Annual assessments are required when almost a year has elapsed since the last time a comprehensive assessment has been performed. A comprehensive assessment includes the MDS+ and a review of RAPs and triggers. Each time an assessment is performed and RAPs and triggers are reviewed, the next annual assessment is due in 365 days. See page 89 of the manual.

Assisted Living/Residential Health Care Regulations

A draft of assisted living/residential health care regulations was provided to the Adult Care Advisory Committee in October. Seventeen organizations and individuals provided written response to the draft regulations. A second draft was distributed to the committee on December 8. Members were requested to provide written responses to the draft at a meeting scheduled for December 19. Additional written responses will be accepted through January 9, 1996. After reviewing the comments, a proposed set of regulations will be developed and submitted for approval. The Kansas Professional Nursing Home Administrator Association, the Kansas Health Care Association and the Kansas Association for Homes and Services for the Aging can be contacted for information on the draft.

Nurse Aide Registry Report

Federal regulations require the nurse aide registry to collect employment information on nurse aides listed on the Kansas Nurse Aide Registry. A number of methods have been explored to meet this Federal requirement. The method acceptable to the Health Care Financing Administration includes a semi-annual reporting by Kansas facilities indicating that a nurse aide has worked at least 8 hours in health care the previous six months.

Enclosed with this *Fact Sheet* is a form which nursing facilities, long term care units in hospitals, intermediate personal care facilities, assisted living facilities and residential health care facilities must complete and return to the Health Occupations Credentialing Section of the Bureau of Adult and Child Care. List all nurse aides employed by the facility in the last six months. Include medication aides, social service designees and activity directors who are also nurse aides.

The bureau recognizes that this is a new regulatory burden for facilities. The bureau will continue to seek an acceptable system which will not be so time consuming. If you have any questions related to this process please contact Marcia Boswell-Carney at (913) 296-0056.

REMINDER: The semiannual report is due in the bureau office by January 10, 1996. Facilities who are unable to complete the nurse aide registry report by January 10, may forward that portion of the report separately to the health occupations credentialing office by January 31, 1996

Kansas Hospice Licensure Law

Effective January 1, 1996, any hospice in Kansas certified to participate in the Medicare program may hold itself out to the public as a licensed hospice. After that date, KSA 65-6202 also prohibits any agency, organization, or other entity not certified to participate in the Medicare program from holding itself out to the public as a hospice or a licensed hospice.

Partnering Group

The regional office of the Health Care Financing Administration (HCFA) established a partnering group. The group is composed of representatives from HCFA, the provider organizations, and state agencies. This group has been meeting on a monthly basis to discuss common issues related to nursing facilities and quality of care for residents. One issue which the group agreed to focus on was staff turnover.

Staff turnover is costly to facilities and has a detrimental effect on resident care. In an article in *Geriatric Nursing*, by Marguerite Birkenstock, methods to calculate turnover was provided. Ms. Birkenstock stated that the cost of turnover can be calculated as four times the monthly salary of the employee who resigned. The turnover cost of an employee earning $6.00 per hour is over $4,000 and an employee at $15.00 per hour the cost is almost $10,500. Cost applied to turnover include recruiting, advertising, screening, interviewing, checking references, establishing employee records, and orientation. The cost of lowered morale and disruption within a work group cannot be calculated.

There are three separate types of figures which will assist facilities in evaluating employment issues: turnover rate, stability rate, and absentee rate. Ms. Birkenstock recommended that full-time and part-time employees be placed in separate groups for analysis.

Quarterly Turnover rate

NUMBER OF EMPLOYEES WHO RESIGNED
DURING THE QUARTER X 100 = TURNOVER RATE
AVERAGE NUMBER ON PAYROLL FOR QUARTER

To determine average number on the payroll, add the number of employees on the payroll at the end of each month and divide by the number of months.

Actual Annual Turnover

Add the turnover rates for the four most recent quarters to obtain actual annual turnover rate.

Absentee rate

NUMBER OF DAYS ABSENT X 100 = ABSENTEE RATE
NUMBER OF DAYS SCHEDULED

Using absentee rate in counseling with individual employees can be a powerful management tool.

For further examples and explanation, it is recommended that facilities obtain a copy of this article.

Birkenstock, M. (1991). From turnover to turnaround: A few simple formulas can help you determine if you have a problem with turnover. Conscientious follow up can tell you why. **Geriatric Nursing**. July/August 1991, 95-97.

Water Plan

42 CFR 483.70(h)(1) and KAR 28-39-163(n)(3) require nursing facilities and long term care units of hospitals to have a plan to ensure that water is available when there is a loss of normal water supply. The intent of the regulations is to assure that each facility has available or has made arrangements for a water supply for at least a 24 hour period when the normal water supply is interrupted. If the water emergency would last longer than 24 hours, the facility should have arrangements with the disaster management agency within the city or county in which the facility is located to provide an on-going emergency water supply or arrange for the transfer of residents.

Calculation of the amount of water needed is determined by the number of residents and their clinical condition. In most instances, a half gallon of potable water per resident and staff member should be sufficient. If the water emergency occurs during a heat wave, additional water may be needed.

Nonpotable water would be used to flush toilets and provide for personal hygiene needs of residents. The amount needed is dependent on how much water is required to flush the toilets in the facility and the care needs of the residents. Most toilets require at least three gallons of water for flushing.

Federal regulations require that the facility include a method for estimating the volume of water required in their plan. At the entrance conference, the team coordinator will ask the administrator about the facility's procedure to ensure water availability.

This requirement does not apply to long term care units in hospitals who do not participate in the Medicare/Medicaid programs.

BACC's Complaint Program

Kansas statutes require all facilities licensed by the Kansas Department of Health and Environment as adult care homes and medical care facilities to post information concerning reporting of abuse, neglect and exploitation of residents to this agency. A number of facilities have been found on survey not to be displaying the required information. Posters containing the required information may be obtained by contacting KDHE Regional Survey offices or the local Area Agencies on Aging.

The Kansas Department of Health and Environment (KDHE) **Adult Care Complaint Program** on January 2, 1996, will implement a new process for handling complaints. The types of complaints and providers that are affected are as follows:

1. General care related complaints for the most part, will now be incorporated into the facility's next survey. However, a special investigation may be conducted independent of a scheduled survey, if KDHE deems it appropriate.

2. Complaints including allegations of abuse, neglect, or exploitation will be processed in one of two ways: 1) onsite investigation; or 2) facility driven investigation and facility completion of the KDHE "Facility Complaint Investigation Report" included with this *Fact Sheet*.

Onsite investigations will be conducted when allegations of abuse, neglect, or exploitation are received from an **identified** individual who is **not a representative** of an adult care home or a home health agency.

Kansas Department of Health and Environment's "Facility Complaint Investigation Report" forms will be completed by the adult care home or the home health agency when **a representative of the facility or agency, or an unidentified individual** has reported an alleged incident of abuse, neglect, or exploitation. At the time the complaint is received by the Adult Care Complaint Program, the reporting facility or agency will be sent a KDHE "Facility Complaint Investigation Report" form for completion. The completed form and the facility's or agency's investigative documentation (as required at C.F.R.483.13(c); K.A.R. 28-39-150(d) must be forwarded to the appropriate KDHE Regional Manager **within seven days** of the date the complaint was initially reported to the Adult Care Complaint Program.

An onsite investigation will not be conducted unless determined necessary following review of the facility's or agency's investigative documentation.

Allegation of Compliance Letters

A facility's plan of correction (POC) can serve as the facility's "Letter of Allegation of Compliance". However, KDHE recommends that facilities do not include their allegation of compliance with their POC. The reason is that if the facility's POC does not meet the requirements or elements defined by HCFA in the new long-term care enforcement regulations, the

POC and the facility's allegation of compliance can not be accepted. The following is an example of the wording a facility might use in their "Letter of Allegation of Compliance":

This letter is the _____ letter of credible allegation of
(Name of Facility)
compliance. We will be in substantial compliance by _____.
(Date)

Enforcement Regulation Information - Provider Brochure

The Kansas Department of Health and Environment has completed its revisions of the long-term care enforcement regulation brochure for providers. Providers receive a copy of this brochure at the time of the survey exit. A copy of the brochure is included in this *Fact Sheet*.

Entrance Conference Form (Form No. NF-513)

KDHE's "Entrance Conference Form" has been revised with the following changes: 1) the additional requirement of the HCFA-1513 Disclosure of Ownership and a list of employees; 2) some of the wording related to residents receiving dialysis, resident fund questionnaires, and the exit conference has been deleted; 3) duplicate requests for the emergency water plan has been deleted; and 4) moved the request for the list of resident council officers up to the category of information needed within one hour. A copy of HCFA 1513 Disclosure of Ownership may be obtained from the survey regional manager. A copy of NF-513 is included with this issue of the *Fact Sheet*.

HCFA'S Mandated Change in the Definition of a "Poor Performing Facility"

In a November 27, 1995, communique from HCFA's Anthony Tirone, states were notified that a mandatory definition for "poor performing facilities" had been developed by HCFA. The Kansas Department of Health and Environment has revised the definition to reflect HCFA's mandatory definition. KDHE's "Policy for Defining a Poor Performing Facility" is included in this *Fact Sheet*.

Notices related to Substandard Quality of Care

Federal enforcement regulations effective July 1, 1995 included new requirements related to nurse aide education. Facilities identified as providing substandard quality of care (SQOC) on a standard survey are prohibited from being a site for nurse aide training for two years. A notice stating this prohibition is mailed to the facility by the Health Occupations Credentialing Program. If ownership of the facility changes within the two year period, the facility may re-apply for approval as a training site.

Between July 1 and December 7, 1995, 63 facilities received SQOC notices related to nurse aide education. The most frequent citations were CFR 483.25(c) pressure sores (18); CFR 483.13(a) restraints (15); and CFR 483.15(f)(1) resident activity programs (13).

The Health Occupations Credentialing Program has received numerous inquiries concerning this issue. Facilities are encouraged to write the program and provide specific and descriptive information on the impact this action has had on the facility. The department is reviewing options which would allow some facilities to serve as clinical training sites.

The new enforcement regulations also requires that the Board of Adult Care Administrators be notified when a licensed administrator's facilities has been found to provide substandard quality of care. The board has decided to approach this as "for information only." KDHE has not changed or expanded criteria for filing formal complaints with the Board.

Health Occupations Update

Health Occupations Update is a new publication developed by the Health Occupations Credentialing program (HOC). The *Update* will be mailed to community colleges, vocational-technical schools, regents institutions and professional associations. The purpose of the publication is to enhance communication between entities providing programs reviewed and approved by HOC. Included will be issues related to nurse aide training, medication aide continuing education, activity directors, social service designees, continuing education for licensed adult care home administrators, dietitians, and speech-language pathologists and audiologists.

Senate Bill 8

Senate Bill 8 requires the Kansas Bureau of Investigation (KBI) to provide the Board of Adult Care Home Administrators criminal history record information related to criminal convictions as necessary for determining initial and continuing qualifications of licensees and applicants for licensure. The Board implemented the statute by requiring KBI reports for new and renewing applicants. In addition, the Board determined there may be instances when a report will be requested for a licensed administrator when a complaint may indicate an unreported criminal conviction.

Medication Aide Curriculum Revision

The Kansas Department of Education has implemented a process to update the certified medication aide curriculum. The revised curriculum is scheduled for review approval during 1996. HOC program has requested that KDHE and representatives from the industry participate in the review.

Surveyor Training

The fall Field Services training conference, *"Surveying Health Care Facilities in the Nineties"* was held October 23-26, in Topeka. Training topics covered were: 1) an update on the new LTC enforcement regulations which included a practice session on assigning deficiencies to the scope and severity grid; 2) time management and organizational skills; 3) survey task number five; 4) resident nutritional assessments, 5) resident care continuum, care planning and implementation; 6) how to cope with difficult co-workers; and 7) using quality indicators in the survey process. One hundred and two BACC staff members and five HCFA staff members attended this training session.

Provider Training on the Long-Term Enforcement Process

The BACC's Field Services administrative staff participated in four provider training sessions which were hosted by the Kansas Health Care Association, the Kansas Association of Homes and Services for the Aging, and the Kansas Professional Nursing Home Administrators Association. These training sessions were held in Hays, Wichita, and Topeka (two sessions).

Resources for Quality Care

KDHE's Office of Health and Environmental Education has ceased operation. The department is in the process of arranging for transfer of the video and pamphlet library to an entity which will be able to provide a similar service to the public. It is planned that the transfer of the educational resources will be accomplished in the next few months. The associations will be provided information concerning this issue as soon as arrangements are finalized.

Everybody Wins!

This is a video library about creative ways to provide quality care to nursing home residents without using restraints. It was developed to help staff in long-term care facilities improve the care they are providing by getting to know their residents better and meeting their unique individual needs. It also seeks to provide individuals who visit nursing homes - for personal or

professional reasons -- with information on why restraint appropriate care is important and how they can help it be achieved.

There is a module to be used with families which contains two videos and an informational brochure. The module for training nursing facility staff includes six videos and a training program. Information concerning these programs can be obtained by contacting:

American Association of Homes and Services for the Aging, 1/800-508-9442
American Health Care Association, 1/800-321-0343

ANE ISSUE STATISTICS 9/1/95 to 11/30/95

Total Complaint Calls Assigned for Investigation - 506

ANE Investigations		Care Issues Investigated	
Total	131	Total	375
September	48	September	143
October	50	October	134
November	33	November	98

Alleged Perpetrators - Administrative Review

	Total Cases	Pending	Declined	Referred
ACH Admin.	1	0	0	1
RNs	3	1	0	2
LPNs	11	7	0	4
CNAs/CMAs	36	11	3	22
MD	0	0	0	0
Pharmacists	1	0	0	1
LMHTs	0	0	0	0

Administrative Hearings on CNAs/CMAs

Held	5
Confirmed	2
Unconfirmed	3
Pending Decision	0
Appeal	2

*Licensure Category	Civil Penalties				Correction Orders			
	1995 Quarters							
	1st	2nd	3rd	4th	1st	2nd	3rd	4th
Inadequate or inappropriate hygiene and skin care	1	4	8		15	25	18	
Inadequate or unqualified staffing	2	3	3		3	5	12	
Inoperable or inaccessible call system	-	1	-		1	0	2	
Inappropriate or unauthorized use of restraints	-	-	2		17	20	17	
Unsafe medication administration or storage	3	-	-		7	5	3	
Inadequate nursing services other than skin care	3	2	3		13	12	18	
Inadequate or inappropriate asepsis technique	-	-	2		6	12	5	
Inadequate or inappropriate dietary/nutritional services	1	-	2		6	9	8	
Unsafe storage of hazardous or toxic substances	-	-	-		2	1	3	
Failure to maintain equipment	-	-	2		2	4	2	
Resident right violations	1	2	4		3	8	10	
Unsafe high water temperature	-	-	-		3	0	1	
Inadequate hot water	-	-	-		-	0	-	
General sanitation and safety	-	-	2		4	4	1	
Other (including inappropriate admission)	-	2	3		2	2	6	
Inadequate rehabilitation services	-	-	-		-	0	-	
Civil Penalties	8	10	3					
Correction Orders					37	45	47	
Bans on Admission	3	5	4					
Denials	1	1	1					

***A correction order or civil penalty may consist of multiple issues summarized within the licensure categories above.**